ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Jan 30, 2020 Case Number: 20-65

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Matthew Hay-Roe

Premise Name: Deer Creek Animal Hospital

Premise Address: 3025 EAst Rose Garden Lane

City: Phoenix State: Arizona Zip Code: 85050

Telephone: 602-404-0066

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Jennifer Zito

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: _____ Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
JAN 30 2020
BY:

C. PATIENT INFORMATION (1):

Name: Malcolm

Breed/Species: Boston Terrier Mix

Age: 3 Sex: Male Color: Black with White

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Matthew Hay-Roe (others supposedly consulted but do not have name(s)).

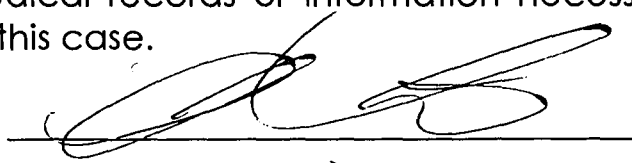
E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

The doctor and veterinary technicians who were working the day of the incident. I do not know who all provided care for him that day.

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: 

Date: 1-27-20

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

See narrative attached hereto as Exhibit "A".

EXHIBIT "A"
(to Veterinary Board Complaint)

I awoke early on the morning of January 13, 2020 to find my dog Malcolm curled up in the corner of my room. He had apparently gotten sick sometime earlier that morning because there was urine and diarrhea on the bed and floors. I cleaned him up, got him dry and warm and sat with him a little while. After observing him for a while it became apparent that something was definitely wrong with him so I began looking for open hospitals in the area since my vet, Deer Creek Animal Hospital ("DCAH"), was not quite open yet. He then vomited on the couch without even attempting to move so I quickly cleaned him up and got myself dressed to take him somewhere. By this time, I realized that DCAH was opening in a few minutes so I phoned them first. I told the receptionist what was happening and asked if they could see him and let me know if I needed to take him somewhere else for treatment. She spoke with a tech who told her they could work us in as an emergency appointment so I went straight there. They got us in a room quickly and a tech soon came in and began doing an initial report for the doctor. While examining Malcolm the tech checked the color of Malcolm's gums. I let her know that I had been checking his gums while at home because my niece, who is an emergency veterinary technician her in Arizona, has always told me to check them because in can be an important indicator. I noted that they looked paler than the last time I had checked them at home, and the tech said they were paler than they should be and that she wanted to get a second opinion on his gum color. She took him back for consultation and said she would bring if back to me **if she could**. She returned with Malcolm and said that he was stable enough to stay with me **for now**. I explained everything. It was apparently that he was very lethargic, lifeless and was moaning in pain the entire time. He couldn't even hold his head up. I explained that he had gone to bed the night before happy, healthy and energetic. Doctor Hay-Roe met with me and went over all the information I could give him. During that time Dr. Hay-Roe also checked Malcolm's gums. They looked even paler now, and I told him also that I had been checking them periodically and that they had definitely become less pink than they first were that morning. Dr. Hay-Roe recommended that they hospitalize him so they could run some tests and blood work on Malcolm and get him on some fluids. I read and signed a treatment plan totaling just shy of $1,000.00, and told the tech to "just do it; we need to find out what is wrong with him". I left him there at approximately 9:30. I called around 11:30 for an update because I had heard nothing since leaving their offices that morning and was told that Dr. Hay-Roe would be calling me shortly with an update. He phoned me just after noon and advised that Malcolm was still listless but no longer moaning. I assumed this was because he had received pain medication. He advised that the ultra sound and x-ray showed a spot that could be a foreign object of some kind down in his lower intestine and also that there was fluid collecting around Malcolm's spleen. Dr. Hay-Roe said they were going to repeat the x-ray in a couple of hours to see if the "object" had moved or changed and he would then call me with another update which would be around 2-2:30. I got a call from Dr. Hay-Roe at 2:19 telling me that they had "something unexpected" happen. He said a technician was seated near the kennels and heard Malcolm take a deep odd breath. She got the doctor, pulled Malcolm out and he was in obviously distressed. They performed CPR and chest compression, but he had died despite their efforts. I rushed straight there. After spending time alone with Malcolm, the doctor came and spoke with me, again told me what had taken place and said they were very sorry and that they did not expect that to happen. The tech also mentioned when she was with me that the they had pulled some of the fluid from around his spleen and that it was blood. I then asked her if that was done before or after he died, and she said after. I requested

that Dr. Hay-Roe perform a Necropsy because I wanted to know what had killed my young dog. He had just turned 3 and was perfectly fine hours earlier. They brought me a revised itemized invoice which had been credited to waive my emergency office visit fee, but included charges for the necropsy and cremation. I paid the bill and asked the tech for copies of the records from the day, including x-rays. She said no problem. She later brought me paper copies of the notes and lab work, and said that she was able to give me the x-rays right then but that they could be emailed to me. I said that was fine. I also got a copy of the invoice which I ultimately paid, but there was no copy of the itemized treatment plan I had approved that morning which was a higher amount than the one I paid. About an hour after leaving their office, I got a call from Hay-Roe advising that the necropsy had shown that Malcolm had eaten part of a plastic fastener commonly found on bread bags, and that it had caused multiple perforations in Malcolm's lower intestine and colon. He said that the damage was extensive enough that Malcolm probably could not have survived surgery. On Wednesday 1/15 I got a call from someone there (I believe it was the tech) advising that my paw print was ready to be picked up. She then mentioned that she still wasn't able to send me the x-rays because of a problem with the server, but that she would get them to me when she could. I went to their office the morning of January 6th to pick up the paw print and while there asked the receptionist to print me a copy of the necropsy report since it had been done after I had left on Monday. She looked it up on the computer and seemed confused as to what I wanted. I again told her and she said she had to go as someone else because she didn't "know how to do that one". When she returned, she said that the tech was busy in surgery but had told her that the doctor should have "notes" and she would tell him when he got in that I had requested them. I then inquired that there should be an actual report, and not just notes, since the necropsy had been done 3 days earlier. She said again she didn't know because it was her first time seeing a necropsy. I confirmed that they would email me both the necropsy report and the x-rays. I received the Necropsy Report a couple hours later via email which turned out to be the same medical records I had previously received but with an added section of notes on the last page summarizing the necropsy results. I did not receive Malcolm's x-rays until January 22, 2020, nine days after I had initially requested them.

After reviewing Malcolm's records and the chain of events, and having them reviewed by my niece and several of her colleagues, including at least three veterinarians, the bloodwork and physical findings do not add up, and the following items were noted:

- Malcolm was never given any type of pain injection despite the obvious signs that he was in great pain which meant he was suffering the entire time.
- Based on Malcolm's blood work, the white blood cell count was normal and showed that he was not septic and had no infection, but they gave him Penicillin which was not necessary.
- There was suspicion of a foreign body, but they gave him Cerenia would should not have been given.
- Despite both the tech and doctor noticing the paling gums, nowhere is it noted in his records.
- The fluids given were not at a maintenance level despite how critical he was.
- There is no evidence that he was given any heat support despite his low temperature.
- There is no evidence that they ever took his blood pressure.

- The glucose levels in the diagnostic records greatly differ from that in the record notes. How were to two conflicting readings obtained and, if it was that low, why was no dextrose given?
- Respiration and pulse numbers are transposed in records and hand written notes.
- Despite the doctor's noted suspicion of a spleen issue and the existing of fluid, they failed to pull the fluid and test it while he was alive which would have shown internal bleeding.
- The "object" was first noted in his small intestine but perforations were supposedly also found in his colon which means the object could not have been in the location noted by the doctor.
- If free fluid was noted in initial imaging, taking repeat x-rays in less than 8 hours would show no change.
- How were such details found in imaging without consult with radiologist?
- No proof of necropsy findings was provided (i.e., pictures, samples). Report consisted only of notes added to existing records.
- Were any fluids or tissue samples obtained for further testing to confirm cause of death?
- CPR was done without any consent from me, written or verbal. I would not have wanted CPR done had I known how critical Malcolm actually was.

At no time, either when I first brought him in, or during the progression of his condition, did they advise that he was critical, advise he might need surgery, or tell me he should be transferred to an emergency facility, nor was it ever suggested that I may need to euthanize him. He sat in that kennel dying, in pain, for five hours. I could have, and would have, rushed him to a facility more equipped to care for him if I had been given any indication that he was critical. I could have lived with my baby passing peacefully and painlessly if that was the situation we were facing, but he suffered needlessly and could have very possibly been saved if proper monitoring and actions had been timely taken.

Case Number 20-65
Narrative Response from Practitioner
February 10, 2020

On January 13, 2020, at 8:05 a.m. Malcolm was initially presented to me for emergency evaluation. A brief triage exam did not reveal any external injuries or uncomfortable areas and he was not vocalizing. I performed an initial vital signs check on Malcolm. I set him down on the floor where he was able to stand on his own. I evaluated his gums which were a pale pink color but had a normal capillary refill time of 2 seconds. His initial body temperature was 98.9 °F and his respiration and pulse rates were within normal ranges, as noted in his record. With this initial presentation of a patient that was able to stand and had no visible difficulty breathing or significant discomfort, he appeared stable enough to wait for a thorough physical exam. I allowed Malcolm to wait in the exam room with his owner/client, Ms. Jennifer Zito.

My technician, Katie Hermanns, then took Ms. Zito's initial history and Malcolm's presenting signs. Ms. Zito stated that Malcolm had seemed fine the day before. However, she awoke to him having had loose, watery brown stool with no blood present in the house. He had urinated as well, then vomited undigested food one time while she was getting ready. Ms. Zito stated Malcolm appeared weak and was moaning at home. She had bathed him as well after 5:00 a.m. Rose informed me of this history, and I entered the exam room at approximately 8:20 a.m. I performed a full physical examination with Ms. Zito present. Malcolm was laterally recumbent and softly moaning when touched, minimally responsive but awake. He again appeared to have pale pink mucous membranes, with no sign of petechiation, cyanosis, hyperpigmentation or ulceration. He was again registering a CRT of 2 seconds. His femoral pulses seemed slightly diminished but were regular and not bounding. He was dehydrated with sticking mucous membranes but no increased skin turgor. His withdrawal reflexes were normal, as he pulled his feet back towards him when they were pinched. Malcolm had no resting nystagmus, and he had a normal rectal tone present with tail lifting. As noted, all other systems examined (eyes, ears, coat/skin, musculoskeletal, lymph nodes, extremities, nasal, and urogenital tracts) were normal.

With this non-specific and short course of illness, there were many possible differential diagnoses to be ruled out, with prognoses widely variable. I believed there was time to work through this list, as Malcolm was lethargic but stable. The potential differential diagnoses on my primary suspicion included both primary GI tract issues (such as parasitic infection, viral infections, foodborne bacterial illness, hemorrhagic gastroenteritis, pancreatitis, gastric ulceration, inflammatory bowel disease, neoplasia and unknown foreign body ingestion), and secondary illnesses causing loss of bladder control and diarrhea/vomiting (such as hypoadrenocorticism, undiagnosed diabetes mellitus with clinical onset of diabetic ketoacidosis, neurologic-acting toxins such as organophosphate pesticides, unknown human NSAID ingestion, endotoxemia, tick-transmitted illness, coccidioidomycosis, plant toxicosis, or myasthenia gravis).

I informed Ms. Zito of some of these primary differential diagnoses. I told her that I would create a treatment plan and cost estimate based on both obtaining a definitive diagnosis and treating problems evident on physical exam. The treatment plan included: (1) hospitalization

with IV fluids, (2) a focused abdominal ultrasound (FAST scan), (3) CBC and Chemistry in-house to aid quick diagnosis, (4) a urinalysis for potential other issues related to his inappropriate urination at home, (5) a PCR diarrhea sample for infectious pathogens and parasites, (6) an anti-nausea injection of maropitant (Cerenia), and (7) a broad-spectrum antibiotic injection of procaine penicillin G in the event infection was identified. Malcolm was rather dull and did not exhibit signs of extreme pain. In my opinion, a pain medication injection may have sedated him further, complicating the diagnostic process. I informed the client that I would be updating this treatment plan as diagnostics were completed and as his condition advanced or declined clinically so as to avoid unnecessary testing or delays. She signed her consent and I advised her that I would call with updates when I was available. I then created a treatment sheet for hospitalization.

Two technicians, Katie Hermanns and Sydney Bartlett, and I began by drawing a pre-treatment blood sample for diagnostics at 9:00 a.m. Malcolm jerked away from the needle inserted into his jugular vein so the sample was drawn from his right front cephalic vein. An IV catheter was successfully placed in his left cephalic vein and we administered a bolus of 30 mL of Normosol at 9:10 a.m., followed by a Cerenia injection and the Procaine Penicillin-G injection. We began spinning down his serum for analysis while we manually checked some of the parameters. A handheld glucometer, which we typically use for initial checks, registered his blood glucose at 21 mg/dL, a very low value. Recognizing this, I calculated an amount of 50% dextrose to add to his IV fluid bag to create an infusion of 5% dextrose and Normosol for correction (see handwritten notes). He had a very elevated hematocrit as well.

I next proceeded to his FAST scan. On scanning, I identified a mild amount of peritoneal effusion with no specific pocketing, and a mildly dilated renal pelvis in the left kidney. His urinary bladder was empty, which prohibited urinalysis. The amount of peritoneal effusion created a fluid margin of less than 1 cm around internal organs, including his spleen and intestines. It would not have been safe to perform fine needle aspiration given the risk that Malcolm might move while the needle was inserted, damaging his organs. I jotted down a shorter list of differentials to keep working down my list.

By 9:26 a.m., Malcolm's complete blood count and chemistry values were available for review. The results showed a blood glucose of 88 (which I used as the standardized value – the blood glucometer's calibration could not be verified before its use). These diagnostics also showed marked hemoconcentration, normal white blood cell levels but a suspected presence of band neutrophils typically released in acute infections, reticulocytosis, a normal platelet level, normal serum electrolytes, normal renal values, and normal hepatic enzymes. Given these findings, I elected to maintain Malcolm at 30 mL/hour, a rate 1.5 times his maintenance requirement, to correct evident dehydration. He was placed in a kennel on a padded blanket and wrapped in a towel. I then continued to see regularly scheduled appointments. I planned to check on Malcolm at my scheduled break at noon, at which time I would examine him and speak with Sydney, who was assigned to his treatment care.

At 12:00 p.m. Malcolm's vital signs were taken, which showed a slightly increased temperature and an increased pulse. His mucous membranes were still a pale pink color and sticking, indicative of dehydration. His mentation remained the same, but he had not been vocalizing while wrapped in his blanket receiving fluids. I performed a rectal exam and produced

no blood or fecal material (making the Diarrhea PCR impossible at the time), and his rectal sphincter did seem loose. He was not interested in eating or standing when prompted this time, and Sydney noted his lethargy. I elected to increase his fluid total by giving him a 100 mL bolus and increasing his maintenance rate to 50 mL/hour.

At this point, I was still uncertain of a definitive diagnosis given the multiple abnormalities both on exam and diagnostics. I decided to take further imaging of Malcolm's abdomen, as this was where I had produced tension on palpation. The radiographs showed a mild serosal detail decrease with a mild gas pattern in small intestines, with no significant dilation. I identified a mildly radio-opaque irregular object in the jejeunum, which was 1.5 cm in length and height and 2 mm in width on orthogonal viewing. Although there was an object, there was no clear evidence of obstruction, perforation or severe peritonitis based on the given view.

Given Malcolm's lethargy and clinical signs, I consulted with both my supervising veterinarian, Suzanne Higgins, and an associate veterinarian, Kelly Grant. They both viewed the radiographs, and Dr. Grant palpated the patient's abdomen, identifying discomfort. He advised me that the patient seemed "pretty sick" and I agreed. The plan we agreed upon was to try and improve some of his parameters with continued IV fluid therapy and repeat radiographs in 2 hours to see if the object would move with peristalsis. Radiographic interpretation with a radiologist was not recommended, as our referrals typically take 24 hours or more. Surgery was not recommended based on the single views without known history of dietary indiscretion, and especially given the client's insistence he had not ingested anything. Transfer was not recommended based on indistinct findings nor indication of his condition markedly worsening. I did not recommend pain medication as it would sedate an already lethargic patient. Cerenia (which blocks substance P transmission) had already been administered.

I began entering Malcolm's medical record into the computer and called Ms. Zito. I informed her that Malcolm's condition seemed about the same as on presentation, with no more moaning, and that we had identified an indistinct object on radiographs. I then asked her if Malcolm was known to ingest foreign objects, if he had been given any raw foods or table scraps, whether any trash had been knocked over, if there were any missing medications (prescription or illicit substances), and what plants may be in the yard and whether he had ingested any to her knowledge. Ms. Zito was clear that there was no known instance of any of these things. I informed her that we planned to increase his fluid rate and recheck radiographs in two hours while keeping him under observation, to see if the object would move at all or if peritoneal effusions would change. The treatment plan proceeded as I had ordered. Malcolm remained draped in a towel, not vocalizing.

At approximately 1:45 p.m Ashley heard Malcolm take an abnormally sharp gasping breath and saw him put his tongue out and stop breathing. She immediately notified me, removed him from the kennel, and found he had no pulse. She began CPR with chest compressions while I calculated emergency drug doses and listened with a stethoscope for pulse. Malcolm produced brown liquid bile from his stomach. He was intubated and given positive pressure oxygen ventilation. We administered IV doses of atropine and epinephrine. We continued these compressions and ventilation for four additional minutes, which produced no responses. Malcolm was declared deceased at 2:19 p.m. Technician Rose Smith attempted to contact Ms. Zito when we began CPR to obtain a directive (she had not been asked previously

because Malcolm did not seem critical prior to his treatment initiation). I then contacted Ms. Zito shortly afterwards. I informed her of what transpired and that I was uncertain of his cause of death. I then elected to perform a non-invasive fine needle aspirate, post-mortem, to identify the peritoneal effusion that was previously evident, and found frank blood.

When Ms. Zito arrived at the hospital, I spoke in the exam room with her in between my afternoon appointments. I apologized for this unexpected tragedy and that we had tried to resuscitate him as best we could. I advised her that I would like to perform a necropsy to establish definitive cause of death other than suspected acute abdominal hemorrhage. She agreed, as she was saddened and wanted an identifiable cause as well. After I left the room, my technician had let the client know we had performed a post-mortem tap and found frank blood.

I performed Malcolm's necropsy at 3:00 p.m. that afternoon. I discovered gross peritoneal hemorrhage with fibrin tags evident, demonstrating that peritoneal hemorrhage had been present for at least one hour but less than 24 hours, as no bowel adhesion was present. Necrosis and venous congestion affected the stomach, small intestines, pancreas and duodenum. The primary perforation in the jejeunum I suspected for the peritoneal hemorrhage was caused by a 1.5 cm-square plastic bag fastener in the jejunum that had perforated the lining and made an ulceration into the adjacent descending colon. Other abdominal organs were affected as well, as noted in the record. I identified the patient's morphologic diagnosis based on gross pathology as marked peritonitis secondary to jejeunal and colonic perforation. With the extent and severity of perforations that were not identified until after death, this patient would have required intensive care and surgery including: immediate exploratory laparotomy with jejeunal and colonic resection and anastomosis, saline lavage, one or more blood transfusions, IV broad-spectrum antibiotic treatment, and post-operative monitoring with ECG and arterial blood pressure measurements. His prognosis (had a GI foreign body been of primary suspicion with hemorrhage) would have been guarded to grave, with a survival rate approximately 25%.

With gross pathology establishing a clear cause of death, now consistent with clinical signs, no samples were obtained for histopathology analysis. My technicians, Rose Smith and Syndey Bartlett, took photos during the necropsy. I had no further contact with Ms. Zito. I understand from her statement that she had further contact with hospital staff to request records and radiographs. I was notified of her request and approved it. I was first notified of her concerns with Malcolm's care when I received her complaint from the board - a surprise to myself and the hospital staff.

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Cameron Dow, DVM
William Hamilton
Brian Sidaway, DVM - ***Recused***

STAFF MEMBERS PRESENT: Tracy A. Riendeau, CVT
Marc Harris, Assistant Attorney General

RE: Case: 20-65
Complainant(s): Jennifer Zito
Respondent(s): Matthew Hay-Roe, DVM (License: 6777)

SUMMARY:
Complaint Received at Board Office: 1/30/20
Committee Discussion: 6/2/20
Board IIR: 7/15/20

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On January 13, 2020, "Malcom," a 3-year-old male Boston Terrier mix was presented to Respondent due to vomiting, diarrhea and lethargy. The dog was hospitalized for diagnostics and treatments.

Later that day, the dog went into cardiac arrest and passed away. Respondent performed a necropsy and found peritonitis secondary to jejunal and colonic perforations.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared telephonically.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Jennifer Zito*
- Respondent(s) narrative/medical record: *Matthew Hay-Roe, DVM*

PROPOSED 'FINDINGS of FACT':

1. On January 13, 2020, Complainant stated in her narrative that she woke up that morning and found the dog curled up in the corner of her room. She had found that the dog had urinated and had diarrhea on the bed and floors. Complainant cleaned up the dog, and while observing him, it was apparent the dog was ill. While looking for a premises that was open, the dog vomited. Complainant realized her regular veterinary premises was open; she called to let them know what was transpiring with the dog and proceeded to the premises.

2. Once Complainant arrived with the dog she was escorted into an exam room where technical staff obtained the dog's vitals. Complainant reported that the dog's gum color was paler then they were earlier. The dog had a weight = 29 pounds, a temperature = 98.9 degrees, a heart rate =140bpm and a respiration rate = 30rpm; BCS 5/9. Technical staff brought the dog back to Respondent to briefly look over the dog. Respondent felt the dog was stable enough to wait with Complainant until he could complete a thorough exam.

3. A short time later Respondent entered the room and examined the dog. He noted that the dog was laterally recumbent and softly moaning when touched; the dog was minimally responsive but awake. Gums were pale-pink with no petechiation or cyanosis but were tacky. Respondent stated in his narrative that with this non-specific and short course of illness, there were many possible differential diagnoses to be ruled out, with prognoses widely variable. He felt there was time to work through the list as the dog was lethargic, but stable. Respondent's rule-outs were – GI foreign body, peritonitis, severe pancreatitis, and unknown ingestion toxicosis.

4. Respondent recommended hospitalization for diagnostics and treatments. An estimate was approved by Complainant and the dog was admitted:

a. Blood was collected;
b. An IV catheter was placed and Normosol fluids were started – bolus 30mLs, then 30mL/hr, maintenance rate;
c. Cerenia 1.5mL (concentration unknown) IV was administered;
d. Pen G 3.0mL (concentration unknown) SQ was administered;
e. AFAST scan revealed mild abdominal effusion present at margins of spleen; indistinct on view – mildly dilated renal pelvis. No distinct foreign material present; and
f. Abdominal radiographs revealed mild serosal detail with mild gas pattern in the small intestines – 1.5cm square shaped foreign material present in jejunum, with 2mm linear appearance on VD view.

5. Initial blood glucose = 21 (on a glucometer); later the glucose was 88 on the in-house blood machine. Respondent stated in his narrative that he calculated an amount of 50% dextrose to add to the dog's IV fluid bag to create an infusion of 5% dextrose and Normosol for correction. There was a calculation written in the medical record however, it is not identified as dextrose. It is not documented in the medical record that dextrose was added to the dog's IV fluids.

6. Blood work revealed the following:

RBC	*12.01*	*5.65 – 8.87*
HCT	*82.9*	*37.3 – 61.7*
HGB	*27.6*	*13.1 – 20.5*

RDW	*23.4*	*13.6 – 21.7*
RETIC	*194.6*	*10 – 110*
PDW	*19.7*	*9.1 – 19.4*

7. The dog was placed in a kennel wrapped in a towel on a padded blanket. Respondent continued seeing scheduled appointments while staff monitored the dog.

8. At 12:00pm, the dog had a temperature = 99 degrees, a heart rate = 170bpm and a respiration rate = 30rpm. The dog had received 224mLs of fluids; an additional 100mLs bolus fluids were administered to the dog and maintenance rate increased to 50mL/hr. The dog was lethargic. Entice was offered but the dog was not interested.

9. Respondent contacted Complainant to discuss his findings. The dog appeared to be about the same as on presentation. An unidentified object was noted on the radiographs therefore Respondent asked if the dog was known to eat foreign material – Complainant responded no. He advised that the plan was to increase the fluid rate and repeat radiographs to see if the foreign object had moved or if the peritoneal effusion would change.

10. At approximately 1:45pm, staff heard the dog take an abnormal breath, put his tongue out and stop breathing. The dog was removed from the kennel and CPR was initiated. Respondent stated that he calculated emergency drug doses and listened with a stethoscope for a pulse. The dog was administered epinephrine 0.3mL IV – the dog vomited brown debris; the dog did not respond and passed away.

11. Respondent contacted Complainant and advise her of what transpired. She came to the premises to visit the dog's remains. Respondent had performed a fine needle aspirate, post-mortem, to identify the peritoneal effusion that was previously evident, and found frank blood. When Complainant arrived to visit the dog, Respondent asked if he could perform a necropsy; Complainant agreed.

12. That afternoon, Respondent performed a necropsy on the dog and discovered gross peritoneal hemorrhage with fibrin tags evident. Necrosis and venous congestion affected the stomach, small intestines, pancreas and duodenum. The primary perforation in the jejunum that was suspected for the peritoneal hemorrhage was caused by a 1.5cm square plastic bag fastener in the jejunum that had perforated the lining and made an ulceration into the adjacent descending colon. With the cause of death clear, no samples were taken for histopathology; staff members took photos during the necropsy.

COMMITTEE DISCUSSION:

The Committee discussed that cerenia helps with intestinal pain in addition to being an anti-nausea medication. They were also comfortable with Respondent giving an injection of an antibiotic in a case like this. The Committee did not have concerns with the amount of IV fluids that were given to the dog either. The discrepancies with the glucose results were likely due to the devices used – one was a hand held unit, while the other was a table top. Dextrose was adequately added to address the low glucose reading.

The Committee discussed that there was a perforation though the jejunum; then the perforation started into the colon, which made anatomical sense. They further discussed that most premises do not have pet owners sign a DNR when admitting for a routine medical work-up. It is a reflex to begin CPR to attempt to save a life before contacting a pet owner to ask if it is their wish to have CPR performed.

With respect to the radiology consult, if the consult turnaround is 24 hours, there was no time to have the consult performed, as the case declined quickly. Furthermore, Respondent consulted with his supervising veterinarian regarding the radiographs. There was nothing obvious on the radiographs that would warrant an emergency exploratory.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 1, with Dr. Sidaway recused.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

Tracy A. Riendeau, CVT
Investigative Division